

Physician Authorization for Medication

Name of Student: _____ Date of Birth: _____

Address: _____ Grade: _____
Street City/State

Name of Licensed Prescriber: _____ Title: _____

Business Telephone No: _____ Emergency No: _____

I have determined that it is necessary for this medication to be administered during school hours.

Medication to be administered: _____

Route: _____ Dosage: _____ Frequency/time(s) of administration: _____

Other specific directions or information regarding this medication/administration:

Optional information:

1. Special side effects, contraindications, or possible adverse reactions to be observed:

2. Other medication being taken by this student: _____

3. The date of the next scheduled visit or when advised to return to prescriber: _____

Signature of licensed prescriber

Date